

MEDICAL ELIGIBILITY DETERMINATION (MED)

Background Information

Assessment Start Date: - -

Month Day Year

Provider-Assessor #

Name of Person Coordinating Assessment _____ Title _____

Agency/Organization _____ Phone Number _____

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	APPLICANT NAME	First: _____ (MI) _____ Last: _____																				
2.	ADDRESS	Street _____ City/Town _____ Cnty _____ State _____ Zip _____ Phone (____) _____																				
3.	SOCIAL SECURITY NO.	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																				
4.	MAINECARE NO. (if applicable)	<input type="text"/>																				
5.	MEDICARE NO.	<input type="text"/>																				
6A.	ASSESSMENT TRIGGER	1. Service Need 3. Significant Medical Change 2. Reassessment due 4. Financial Change <input type="checkbox"/>																				
6B.	PROGRAM ASSESSMENT REQUESTED (Choose only one.)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> 1. Long Term Care Advisory 2. Adult Day Care Program 3. BEAS Home Maker 4. MaineCare Day Health 5. Consumer Directed PCA 6. Home Based Care 7. Phys. Dis. HCB 8. Elderly HCB 9. Adults w/ Disability HCB 10. PDN - Level I, II, III 11. Adult Family Care Home 12. Level V - Extended PDN 13. NF Assessment 14. 20-day Medicare/MaineCare 15. Medicare to MaineCare 16. 20-day copay to NF MaineCare </td> <td style="width: 50%; border: none;"> 17. 30-day Community MaineCare NF 18. Advisory to MaineCare Update 19. Adv. Medicare to Private Pay NF 20. Continuing Stay Review 21. Extraordinary Circumstances to NF 22. Katie Beckett 23. NF PDN - Level IV 24. Congregate Housing 25. TBI 26. MaineCare Home Health 27. PDN Medication - Level VI 28. PDN Venipuncture Only - Level VII 29. Consumer Directed HCB </td> </tr> </table> <input type="checkbox"/>	1. Long Term Care Advisory 2. Adult Day Care Program 3. BEAS Home Maker 4. MaineCare Day Health 5. Consumer Directed PCA 6. Home Based Care 7. Phys. Dis. HCB 8. Elderly HCB 9. Adults w/ Disability HCB 10. PDN - Level I, II, III 11. Adult Family Care Home 12. Level V - Extended PDN 13. NF Assessment 14. 20-day Medicare/MaineCare 15. Medicare to MaineCare 16. 20-day copay to NF MaineCare	17. 30-day Community MaineCare NF 18. Advisory to MaineCare Update 19. Adv. Medicare to Private Pay NF 20. Continuing Stay Review 21. Extraordinary Circumstances to NF 22. Katie Beckett 23. NF PDN - Level IV 24. Congregate Housing 25. TBI 26. MaineCare Home Health 27. PDN Medication - Level VI 28. PDN Venipuncture Only - Level VII 29. Consumer Directed HCB																		
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7.	GENDER	1. Male 2. Female <input type="checkbox"/>																				
8.	RACE/ETHNICITY (Optional)	1. American Indian/Alaskan 4. Hispanic 2. Asian/Pacific 5. White 3. Black 6. Other <input type="checkbox"/>																				
9.	BIRTH DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																				
10A.	MARITAL STATUS	1. Never married 3. Widowed 5. Divorced <input type="checkbox"/> 2. Married 4. Separated																				
10B.	CITIZENSHIP	1. U.S. Citizen 2. Legal alien 3. Other <input type="checkbox"/>																				
11.	PRIMARY LANGUAGE	0. English 2. Spanish 1. French 3. Other _____ <input type="checkbox"/>																				
12.	CURRENT INCOME SOURCE FOR APPLICANT & HOUSEHOLD	<table style="width: 100%; border: none;"> <tr> <td colspan="2" style="border: none;">(Check all that apply.)</td> <td style="border: none;">App. Hshld.</td> <td style="border: none;">g/h. SSI</td> <td style="border: none;">App. Hshld.</td> </tr> <tr> <td style="border: none;">a/b. Social Security</td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> <td style="border: none;">i/j. Other</td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">c/d. Private Pension</td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> <td style="border: none;">k/l. Assets >\$2000.00</td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td style="border: none;">e/f. VA Benefits</td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> <td style="border: none;"><input type="checkbox"/> <input type="checkbox"/></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table>	(Check all that apply.)		App. Hshld.	g/h. SSI	App. Hshld.	a/b. Social Security	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	i/j. Other	<input type="checkbox"/> <input type="checkbox"/>	c/d. Private Pension	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	k/l. Assets >\$2000.00	<input type="checkbox"/> <input type="checkbox"/>	e/f. VA Benefits	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		
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e/f. VA Benefits	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>																				

13.	CURRENT OR POTENTIAL PAYMENT SOURCE (Code a response in each box.)	0. Not eligible 1. Eligible 2. Eligibility pending (application filed) 3. Eligibility anticipated (application not yet filed) 4. Unknown		
		<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;"> a. Community MaineCare (Routine home health, PDN) <input type="checkbox"/> a b. HCB - Elderly, AD <input type="checkbox"/> b c. HCB - Phys. Dis. <input type="checkbox"/> c d. NF MaineCare <input type="checkbox"/> d e. Medicare Part A <input type="checkbox"/> e f. Medicare Part B <input type="checkbox"/> f </td> <td style="width: 40%; border: none;"> g. Champus <input type="checkbox"/> g h. VA <input type="checkbox"/> h i. Title XX <input type="checkbox"/> i j. Other <input type="checkbox"/> j </td> </tr> </table>	a. Community MaineCare (Routine home health, PDN) <input type="checkbox"/> a b. HCB - Elderly, AD <input type="checkbox"/> b c. HCB - Phys. Dis. <input type="checkbox"/> c d. NF MaineCare <input type="checkbox"/> d e. Medicare Part A <input type="checkbox"/> e f. Medicare Part B <input type="checkbox"/> f	g. Champus <input type="checkbox"/> g h. VA <input type="checkbox"/> h i. Title XX <input type="checkbox"/> i j. Other <input type="checkbox"/> j
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14.	LOCATION AT TIME OF ASSESSMENT & USUAL RESIDENCE	1. Hospital 5. Nursing Home 2. Home/apartment 6. Assisted Living Unit 3. Congregate housing 7. Adult Family Care Home 4. Residential Care Facility 8. Adult Foster Home 9. Other _____		
		A. Location at time of assessment <input type="checkbox"/> B. Usual place of residence <input type="checkbox"/>		
15.	USUAL LIVING ARRANGEMENT	Lives with: (Check all that apply.)		
		<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;"> a. Alone <input type="checkbox"/> a b. With spouse <input type="checkbox"/> b c. With children <input type="checkbox"/> c d. With other residents <input type="checkbox"/> d </td> <td style="width: 70%; border: none;"> e. With parents <input type="checkbox"/> e f. With friend <input type="checkbox"/> f g. With sibling <input type="checkbox"/> g h. Sig. other <input type="checkbox"/> h i. Other _____ <input type="checkbox"/> i </td> </tr> </table>	a. Alone <input type="checkbox"/> a b. With spouse <input type="checkbox"/> b c. With children <input type="checkbox"/> c d. With other residents <input type="checkbox"/> d	e. With parents <input type="checkbox"/> e f. With friend <input type="checkbox"/> f g. With sibling <input type="checkbox"/> g h. Sig. other <input type="checkbox"/> h i. Other _____ <input type="checkbox"/> i
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16.	NO. IN HOUSEHOLD (Incl. applicant)	Other than in institution/residential care facilities <input type="text"/> <input type="text"/>		
17.	RESPONSIBILITY/LEGAL GUARDIAN (For only those items with supporting documentation)	(Check all that apply.)		
		<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;"> a. Legal guardian <input type="checkbox"/> a b. Other legal oversight <input type="checkbox"/> b c. Durable power attorney/ health care proxy <input type="checkbox"/> c </td> <td style="width: 70%; border: none;"> d. Family member responsible <input type="checkbox"/> d e. Applicant responsible <input type="checkbox"/> e f. Other <input type="checkbox"/> f g. Unknown <input type="checkbox"/> g </td> </tr> </table>	a. Legal guardian <input type="checkbox"/> a b. Other legal oversight <input type="checkbox"/> b c. Durable power attorney/ health care proxy <input type="checkbox"/> c	d. Family member responsible <input type="checkbox"/> d e. Applicant responsible <input type="checkbox"/> e f. Other <input type="checkbox"/> f g. Unknown <input type="checkbox"/> g
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18.	ADVANCED DIRECTIVES (For only those items with supporting documentation)	(Check all that apply.)		
		<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;"> a. Living will <input type="checkbox"/> a b. Do not resuscitate <input type="checkbox"/> b c. Do not hospitalize <input type="checkbox"/> c d. Organ donation <input type="checkbox"/> d e. Autopsy request <input type="checkbox"/> e </td> <td style="width: 70%; border: none;"> f. Feeding restrictions <input type="checkbox"/> f g. Medication restrictions <input type="checkbox"/> g h. Other _____ <input type="checkbox"/> h i. NONE OF ABOVE <input type="checkbox"/> i </td> </tr> </table>	a. Living will <input type="checkbox"/> a b. Do not resuscitate <input type="checkbox"/> b c. Do not hospitalize <input type="checkbox"/> c d. Organ donation <input type="checkbox"/> d e. Autopsy request <input type="checkbox"/> e	f. Feeding restrictions <input type="checkbox"/> f g. Medication restrictions <input type="checkbox"/> g h. Other _____ <input type="checkbox"/> h i. NONE OF ABOVE <input type="checkbox"/> i
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19. CONTACTS A. Name _____ Address _____ _____ Relationship _____ Telephone _____ Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No	B. Name _____ Address _____ _____ Relationship _____ Telephone _____ Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No
20. REFERRING PHYSICIAN _____ Address _____ _____ Telephone _____	CONTINUING PHYSICIAN _____ Address _____ _____ Telephone _____

Homebound 0 - No 1 - Yes

Agency Name: _____

Applicant Name: _____

Provider-Assessor # -

Social Security # - -

Assessment Date - -

SECTION C.4B. COGNITION

Enter the code that most accurately describes the person's cognition for the last 7 days.

1. MEMORY FOR EVENTS:

- 0 Can recall details and sequences of recent experiences and remember names of meaningful acquaintances.
- 1 Cannot recall details or sequences of recent events or remember names of meaningful acquaintances.
- 2 Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting.
- 3 Cannot recall entire events or name of spouse or other living partner even with prompting.

2. MEMORY AND USE OF INFORMATION:

- 0 Does not have difficulty remembering and using information. Does not require directions or reminding from others.
- 1 Has minimal difficulty remembering and using information. Requires direction and reminding from others one to three times per day. Can follow simple written instructions.
- 3 Has difficulty remembering and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions.
- 4 Cannot remember or use information. Requires continual verbal reminding.

3. GLOBAL CONFUSION:

- 0 Appropriately responsive to environment.
- 1 Nocturnal confusion on awakening.
- 2 Periodic confusion during daytime.
- 3 Nearly always confused.

4. SPATIAL ORIENTATION:

- 0 Oriented, able to find and keep his/her bearings.
- 1 Spatial confusion when driving or riding in local community.
- 2 Gets lost when walking neighborhood.
- 3 Gets lost in own home or present environment.

5. VERBAL COMMUNICATION:

- 0 Speaks normally.
- 1 Minor difficulty with speech or word-finding difficulties.
- 2 Able to carry out only simple conversations.
- 3 Unable to speak coherently or make needs known.

C.4B TOTAL COGNITIVE SCORE

Return to Section C5 on page 2.

SECTION D.2B. BEHAVIOR

Enter the code that most accurately describes the person's behavior for the last 7 days.

1. SLEEP PATTERNS:

- 0 Unchanged from "normal" for the consumer.
- 1 Sleeps noticeably more or less than "normal."
- 3 Restless, nightmares, disturbed sleep, increased awakenings.
- 4 Up wandering for all or most of the night, inability to sleep.

2. WANDERING:

- 0 Does not wander.
- 1 Does not wander. Is chair bound or bed bound.
- 2 Wanders within the facility or residence and may wander outside, but does not jeopardize health and safety.
- 3 Wanders within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.
- 4 Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

3. BEHAVIORAL DEMANDS ON OTHERS:

- 0 Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.
- 1 Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.
- 3 Attitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing.
- 4 Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The consumer's behavior cannot be changed to reach the desired outcome through respite, in-home services, or existing facility staffing even given training for the caregiver.

4. DANGER TO SELF AND OTHERS:

- 0 Is not disruptive or aggressive, and is not dangerous.
- 1 Is not capable of harming self or others because of mobility limitations (is bed bound or chair bound).
- 2 Is sometimes (1 to 3 times in the last 7 days) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment.
- 3 Is frequently (4 or more times during the last 7 days) disruptive or aggressive, or is frequently extremely agitated or anxious; and professional judgment is required to determine when to administer prescribed medication.
- 5 Is dangerous or physically abusive, and even with proper evaluation and treatment may require physician's orders for appropriate intervention.

5. AWARENESS OF NEEDS/JUDGMENT:

- 0 Understands those needs that must be met to maintain self care.
- 1 Sometimes (1 to 3 times in the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 2 Frequently (4 or more times during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation.
- 3 Does not understand those needs that must be met for self care and will not cooperate even though given direction or explanation.

D.2B TOTAL BEHAVIOR SCORE

Return to Section D3 on page 2.

Agency Name: _____
 Provider-Assessor #

Applicant Name: _____
 Social Security #
 Assessment Date

SECTION P. INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. IADL SELF-PERFORMANCE CODES:
 0. INDEPENDENT: (with/without assistive devices)—No help provided.
 1. INDEPENDENT WITH DIFFICULTY: Person performed task, but did so with difficulty or took a great amount of time to do so.
 2. ASSISTANCE/DONE WITH HELP: Person involved in activity but help (including supervision, reminders, and/or physical "hands-on" help) was provided.
 3. DEPENDENT/DONE BY OTHERS:
 Full performance of the activity was done by others The person was not involved at all each time the activity was performed.
 8. Activity did not occur.

2. IADL SUPPORT CODES:
 0. No support provided.
 1. Supervision/cueing provided.
 2. Set-up help only.
 3. Physical assistance was provided.
 4. Total dependence—the person was not involved at all when the activity was performed.
 8. Activity did not occur.

	1	2
SELF-PERFORMANCE		
SUPPORT		

1. DAILY INSTRUMENTAL ACTIVITIES <i>Code for level of independence based on person's involvement in the activity in the last 7 days</i>	a. Meal Preparation: Prepared breakfast and light meals.		
	b. Main Meal Preparation: Prepared or received main meal <input type="checkbox"/> Meals on Wheels _____ times per week		
	c. Telephone: Used telephone as necessary, e.g., able to contact people in an emergency.		
	d. Light Housework: Did light housework such as dishes, dusting (on daily basis), making own bed.		
2. OTHER INSTRUMENTAL ACTIVITIES OF DAILY LIVING <i>Code for level of independence based on person's involvement in the activity in the last 14 days</i>	a. Managing Finances: Managed own finances, including banking, handling checkbook, paying bills.		
	b. Routine Housework: Did routine housework such as vacuuming, cleaning floors, trash removal, cleaning bathroom, as needed.		
	c. Grocery Shopping: Did grocery shopping as needed (excluding transportation).		
	d. Laundry: Indicate: <input type="checkbox"/> in home <input type="checkbox"/> out of home Did laundry in home or at laundry facility (excluding transportation).		
3. TRANSPORTATION <i>Check all that apply for level of independence based on person's involvement in the last 30 days.</i>	<input type="checkbox"/> a. Person drove self or used public transportation independently to get to medical, dental appointments, necessary engagements, or other activities.		
	<input type="checkbox"/> b. Person needed arrangement for transportation to medical, dental appointments, necessary engagements, or other activities.		
	<input type="checkbox"/> c. Person needed transportation to medical, dental appointments, necessary engagements, or other activities.		
	<input type="checkbox"/> d. Person needed escort to medical, dental appointments, necessary engagements, or other activities.		
	<input type="checkbox"/> e. Activity did not occur.		
4. PRIMARY MODES OF LOCOMOTION	<i>Code for the primary mode of locomotion for (a) indoors and (b) outdoors from the following list:</i>		
	0. No assistive device 1. Cane 2. Walker/crutch 3. Scooter (e.g. Amigo) 4. Wheelchair 5. Activity does not occur	a. Indoors	b. Outdoors

SECTION Q. ENVIRONMENTAL ASSESSMENT

1.	If person resides in a facility such as a NF, RCF, or hospital, check here and proceed to Section R.		
2.	HOME ENVIRONMENT <i>(Check any of the following that makes home environment hazardous or uninhabitable. If none apply, check NONE OF ABOVE. If temporarily in institution, base assessment on home visit)</i>	a. Lighting (including adequacy of lighting, exposed wiring)	a.
		b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)	b.
		c. Bathroom and toiletroom environment (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)	c.
		d. Kitchen environment (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)	d.
		e. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)	e.
		f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)	f.
		g. Access to home (e.g., difficulty entering/leaving home)	g.
		h. NONE OF ABOVE	h.
3.	TRADE OFFS <i>Check all that apply.</i>	Because of limited funds, during the last month, person made trade-offs in purchasing the following: <input type="checkbox"/> a. home heat <input type="checkbox"/> d. prescribed medications <input type="checkbox"/> b. adequate food <input type="checkbox"/> e. home care. <input type="checkbox"/> c. necessary physician care <input type="checkbox"/> f. NONE OF ABOVE	

SECTION R. MOOD

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	<i>Code for behavior in last 30 days irrespective of the assumed cause.</i> 0. Indicator not exhibited 1. Indicator of this type exhibited up to 5 days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
VERBAL EXPRESSIONS OF DISTRESS	a. Person made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." b. Repetitive questions—e.g., "Where do I go? What do I do?" c. Repetitive verbalizations—e.g., calling out for help. ("God help me.") d. Persistent anger with self or others—e.g., easily annoyed; anger at placement in nursing home; anger at care received e. Self-deprecation—e.g., "I am nothing; I am of no use to anyone." f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related)—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern LOSS OF INTEREST l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand-wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in longstanding activities or being with family/friends p. Reduced social interaction	a.
			b.
			c.
			d.
			e.
			f.
			g.
			h.
			i.
			j.
2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up," console or reassure the person over the last 7 days. 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	MOOD	Person's current mood status compared to person's status 180 days ago. 0. No change 1. Improved 2. Declined	

COMMUNITY OPTIONS

CODING SHEET FOR CARE PLAN SUMMARY/OUTCOME

1. FUNDING SOURCE	
Enter the payment code for the funding source which will pay for the recommended service.	15 Title III
1 MaineCare Home Health	16 Assisted Living
2 PDN - Level I, II, III	17 Adult Family Care Home – 1
3 Level V Extended PDN	18 Adult Family Care Home – 2
4 Level IV NF PDN	19 Adult Family Care Home – 3
5 Elderly HCB	20 Other
6 Adults with Disabilities HCB	29 Consumer Directed HCB
7 Physically disabled HCB	For the Medicare/3rd Party Payor Block, use the following codes:
8 Congregate housing services	21 Medicare
9 Katie Beckett	22 3rd Party Payors (BC/BS, Champus, VA, LTC Insurance)
10 Consumer Directed PCA	23 Community MaineCare
11 MaineCare Day Health	24 Consumer's Funds
12 Adult Day Program	25 Nursing Facility
13 BEAS Homemaker	
14 Home Based Care	

2. SERVICE CATEGORY	
Enter the appropriate code from the following list to indicate the service category recommended to meet the need.	23 Emergency response installation
1 Administrative care management	24 Psychiatric RN–visit
2 Face-to-face care management	25 Master's social work–visit
3 Adult day care	26 Master's social work–hour
4 Personal care assistant (hour)	27 Social services
5 Personal care assistant (live-in)	28 Transportation
6 Personal care assistant (night)	29 Adult family care home – Level 1
7 Homemaker	30 Adult family care home – Level 2
8 RN–visit	31 Adult family care home – Level 3
9 RN–hour	32 Family
10 LPN–visit	33 Friend
11 LPN–hour	34 Residential care
12 Home health aide–visit	35 Independent living assessment
13 Home health aide–hour	36 Certified occupational therapy aide
14 Certified nurse's aide–visit	37 Certified physical therapy aide
15 Certified nurse's aide–hour	38 Meals on Wheels
16 Physical therapy–visit	39 Comprehensive care management
17 Physical therapy–hour	40 Environmental mods
18 Occupational therapy–visit	41 Licensed speech therapy assistant
19 Occupational therapy–hour	42 Psychiatric medication services
20 Speech therapy–visit	43 Health assessment
21 Speech therapy–hour	44 Institutional respite-NF
22 Emergency response	45 Institutional respite-residential care
	46 Personal care assistant (visit)

4. DURATION
Enter the Start and End Dates for the proposed service.

5. UNIT CODE
Enter the unit of time which is used in calculating the cost of this service, using the following list.
1 = 15 minutes 8 = visit
2 = 1/2 hour 9 = mile
3 = hour 10 = per trip
4 = day 11 = installation
5 = night 12 = Lifetime
6 = week 13=PRN Hour
7 = month 14=PRN Visit

6. NUMBER OF UNITS
Enter the number of units needed per month to meet the person's needs.

7. RATE
Enter the current rate for this service based on the maximum allowable MaineCare rate for that specific unit of service as found in the appropriate MaineCare manual.

8. TOTAL COST
Calculate the total cost per month for this service.

3. REASON CODES		
Enter the reason code for recommended service/need being met using the following list of codes.		
1 Information/consultation	22 Access to emergency help	49 Nursing-assessment sign/symptoms infection
2 Careplan development/service coordination/monitoring	23 Supervision	50 Nursing-skilled observation, intervention cardiopulmonary
3 Needs evaluation/skills training/consumer instruction	24 Community support/outreach assistance in accessing resources/financial assistance	51 Nursing-observation- mobility, gait, balance, endurance
4 Medical assessment/consultation/education/teaching	25 Crisis surveillance	52 Nursing-skilled observation, intervention genitourinary
5 Nursing treatments/dressing change/monitoring	26 Monitoring supervision–daytime only	53 Nursing-assess, maintain or improve skin integrity
6 Medication prep/administration	27 Monitoring supervision–nighttime only	54 Nursing-Assess intensity level, frequency, location and manage pain
7 Early Loss ADLs: bathing, dressing	28 Other	55 Nursing-skilled observation, intervention gastrointestinal system
8 Late Loss ADLs: eating, toileting, transferring, locomotion, bed mobility	29 Environmental modifications	56 Nursing-assessment emotional-social status
9 Personal hygiene: shampoo, nail care, feet and back washing, routine skin care	30 Monitor, administer, and/or prefill of psychiatric medications	57 Nursing-Assess, evaluate disease process
10 Daily IADLs: meal preparation, main meal, light housework, telephone use	31 Venipuncture	58 Teach disease process and compliance
11 Other IADLs: Laundry, routine housework, grocery shopping, managing finances	32 Early loss ADLs/bathing	59 Assess and monitor medication compliance, side effects
12 Physical therapy–consultation/evaluation	33 Early loss ADLs/dressing	60 Social worker-assess coping skills/therapy for stressors
13 Physical therapy treatment program, ROM, ambulation, maintenance of function	34 Late loss ADL/transfer	61 Social worker-Counseling for long term planning/decision making
14 Occupational therapy–consultation/evaluation	35 Late ADLs/eating	62 Social worker-Counseling for adjustment to functional limitations
15 Occupational therapy–treatment (skill training-ADLs-IADLS)	36 Late ADLs/toilet	63 Caregiver relief
16 Speech therapy–consultation/evaluation	37 Late ADLs/bed mobility	
17 Speech therapy–treatment program	38 Late ADLs/locomotion	
18 Mental Health–consultation/evaluation	39 Daily IADLs/light meal/main meal	
19 Mental Health–treatment program	40 Daily IADLs light housekeeping/dusting/washing dishes/making bed	
20 Socialization, activities, stimulation	41 Other IADLs/laundry	
21 24-hour supervision (in private home or residential care setting/structured environment)	42 Other IADLs/grocery shopping	
	43 Other IADLs/grocery shopping/laundry	
	44 Other IADLs/house work	
	45 Transportation to medical care appointments	
	46 Transportation for non-medical careplan needs	
	47 Nursing education/teaching	
	48 Nursing-assess wound/provide wound care	

OUTCOME PAGE

DENIAL CODES		
ACTION CODES:	REASON:	
(choose one):	1 Not medically eligible	11 Service no longer available
1 Reduction in service	2 Not financially eligible	12 Death
2 Program denied (based on eligibility criteria)	3 Change in level of care	13 Other
3 Program terminated (based on circumstances, choice)	4 Consumer refused service	14 Non-payment of co-pay
4 Program change	5 Consumer refused copay	15 Non-compliance with POC
5 Other	6 Institutionalized	16 Change type of care provider
6 Service Category Change	7 Moved out of state	17 Change number/freq. of service
7 Program Suspended	8 Other community service/funding source	18 Consumer requested change
	9 Maximum allowance/cap reached	19 Significant change-health/welfare risk
	10 No willing provider	

ELIGIBILITY DETERMINATION

Agency Name: _____ Applicant Name: _____
 Provider-Assessor # - Social Security # - -
 Assessment Date: - -

ADULT FAMILY CARE HOMES - LEVEL 1

Cueing/Limited Assistance

AF.1. a. In Section E, (Physical Functioning/Structural Problems), are the ADLs from items d, e, f, and 4 (dressing, eating, toilet use, and bathing) coded with a 5 (cueing required 7 days a week) in self-performance and 2,3, or 5 in support? OR Yes ___ No ___

b. In Section E, Physical Functioning/Structural Problems, were 2 or more of the following 7 ADLs: bed mobility, transfer, locomotion, eating, toilet use, bathing, or dressing coded with a 2, 3 or 4 in self-performance and coded with a 2 or 3 in support? Yes ___ No ___

If the answer to either of these questions is "YES," score this section with a "1." The consumer appears to be eligible for Level 1 of Adult Family Care Homes.

ADULT FAMILY CARE HOMES - LEVEL 2

Extensive Assistance

AF.2. a. In Section E, (Physical Functioning/Structural Problems), is at least one ADL from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 3 or 4 (extensive assistance or total dependence) in self-performance and a 2 or 3 in support? AND Yes ___ No ___

b. In Section E, (Physical Functioning/Structural Problems), are at least two (2) additional ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes ___ No ___

If the answer to both of these questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 2 of Adult Family Care Homes.

Cognitive Impairment

AF.3. a. Is Section C1a (short term memory) coded with a 1? Yes ___ No ___

b. In Section C2 (memory recall) are 1 or 2 boxes checked in C2a-C2d or is C2e, None of the Above, checked (Person is able to recall no more than 2 items)? Yes ___ No ___

c. Is Section C3 coded with a 2 or 3? Yes ___ No ___

d. In Section E, (Physical Functioning/Structural Problems), are 2 or 3 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes ___ No ___

If the answer to all of the above questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 2 of Adult Family Care Homes.

Behavioral Symptoms

AF.4. a. In Section D, Problem Behavior, are one or more of the behaviors from items a, b and c (wandering, verbally abusive, physically abusive) coded with a 2 or 3? Yes ___ No ___

OR are at least 3 of the behaviors from items a, b, c and d coded with a 1 (behavior of this type occurred on 1-3 days only)? Yes ___ No ___

b. In Section E, (Physical Functioning/Structural Problems), are 2 or 3 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes ___ No ___

If the answer to both of these questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 2 of Adult Family Care Homes.

ADULT FAMILY CARE HOMES - LEVEL 3

Cognitive Impairment

AF.5. a. Is Section C1a (short term memory) coded with a 1? Yes ___ No ___

b. In Section C2 (memory recall) are only 1 or 2 boxes checked in C2a-C2d or is C2e, None of the Above, checked (Person is able to recall no more than 2 items)? Yes ___ No ___

c. Is Section C3 coded with a 2 or 3? Yes ___ No ___

d. In Section E, (Physical Functioning/Structural Problems), are at least 4 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes ___ No ___

If the answer to all of the above questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 3 of Adult Family Care Homes.

Behavioral Symptoms

AF.6. a. In Section D, Problem Behavior, are one or more of the behaviors from items a, b and c (wandering, verbally abusive, physically abusive) coded with a 2 or 3? Yes ___ No ___

OR are at least 3 of the behaviors from items a, b, c and d coded with a 1 (behavior of this type occurred on 1-3 days only)? Yes ___ No ___

b. In Section E, (Physical Functioning/Structural Problems), are at least 4 ADLs from items a, b, c, e, and f (bed mobility, transfer, locomotion, eating, or toilet use), coded with a 2, 3, or 4 (limited assistance, extensive assistance, or total dependence) in self-performance and coded with a 2 or 3 in support? Yes ___ No ___

If the answer to both of these questions is "YES," then score this section with a "1." The consumer appears to be eligible for Level 3 of Adult Family Care Homes.

ELIGIBILITY DETERMINATION

Agency Name: _____ Applicant Name: _____
 Provider-Assessor # - Social Security # - -
 Assessment Date: - -

PDN/PCS LEVEL 3

R.3.A In Clinical Detail, Section E, Physical Functioning/Structural Problems, were 2 of the following 5 Shaded ADLs (bed mobility, transfer, locomotion, eating, toilet use) coded with a 2, 3, or 4 in **Self-Performance** AND a 2 or 3 in **Support**? Yes ___ No ___

R.3.B ADL Needs Score: If the answer to R.3.A is 'yes' then score this section with a '1'.

R.3.C PDN-Level 3 Eligibility Determination (RN.E + R.3.B) Yes ___ No ___
 a. In RN.E, is the PDN Nursing Score '1' or more? Yes ___ No ___
 b. In R.3.B, is the ADL Needs Score '1'?

If the answer to both of these questions is YES, score '1' in the box. The person appears to be eligible for PDN-Level 3. Otherwise, the person appears **NOT** to be eligible for PDN-Level 3.

PDN/PCS Level V

EXP.1. In Section A, was item 9 (Ventilator/Respirator) coded with a 4 (nursing services needed 7 days a week)? Yes ___ No ___
 If the answer is YES, then person appears to be medically eligible for Extended PDN. Score 1 in the box.
 If the answer is NO, then proceed to EXP.2.

EXP.2a. In Section A, was one of the items from 1 (Injections/IV Feedings), 2 (Feeding Tube), 3 (Suctioning/Trach Care), 4 (Treatment/Dressings), 8 (Comatose), or 10 (Uncontrolled Seizure) coded with a 6 (service needed at least once every 8 hours, 7 days a week)? Yes ___ No ___
2b. In Section A, were 2 additional items from 1, 2, 3, 4, 8, or 10 coded with a 4? Yes ___ No ___
 If the answer to BOTH 2a. and 2b. is YES, then person appears to be medically eligible for PDN-Level 5. Score 1 in the box.
 If NO, then person appears to NOT be medically eligible for PDN-Level 5.

PDN Level VI -- MEDICATION SERVICES FOR PERSONS WITH SEVERE AND DISABLING MENTAL ILLNESS

R.10. a. Is there a physician certification in the person's record verifying the person's eligibility or coverage for services under Section 17? Yes ___ No ___
b. Has a physician certified that use of outpatient services is contraindicated for this person? Yes ___ No ___
 If the answer to both of these questions is "YES", then score this section with a "1".

R.11. a. In Section G, Medication, is G1a, Preparation/Administration, coded with a 6? Yes ___ No ___
b. In Section G, Medication, is G1b, Compliance, coded with a 4? Yes ___ No ___
 If the answer to either of these questions is "YES", then score this section with a "1".

If the answer to both R.10. and R.11. is scored with a "1" then this person appears to be eligible for Medication Services under Private Duty Nursing. Otherwise, this person appears NOT to be eligible for Medication Services.

PDN Level VII -- VENIPUNCTURE ONLY SERVICES

R.12. a. Is there a physician order in the person's record for **only** venipuncture services on a regular basis? Yes ___ No ___
b. Has a physician certified that use of outpatient services is contraindicated for this person? Yes ___ No ___
c. In Section B, Special Treatments and Therapies, is B.1.e, Venipuncture, coded with a 1, 2, or 3? Yes ___ No ___
 If the answers to R.12 a., b., and c. are "YES", then score this section with a "1". Person appears to be eligible for Venipuncture Services under Private Duty Nursing.

Agency Name: _____
Provider-Assessor # []-[]
Assessment Date: []-[]-[]

Applicant Name: _____
Social Security # []-[]-[]-[]-[]-[]
MaineCare # []-[]-[]-[]-[]-[]

SECTION T. ASSESSMENT TYPE/VERSION

Table with columns for Assessment Type/Version and checkboxes for various program eligibilities (e.g., Long Term Care Advisory, BEAS Home Maker, etc.)

SECTION U. NF MEDICAL ELIGIBILITY

1. Based on this assessment, the consumer appears to be medically eligible for NF level of care. Complete regardless of consumer choice. 0 - No 1 - Yes

SECTION V. AWAITING PLACEMENT

SECTION W. NF/HOSP/HHA DATES

SECTION X. NF FACILITY

SECTION Y. LATE SUBMISSION

SECTION Z. COMMUNITY BENEFITS table with columns: FUNDING SOURCE (from Care Plan), PROVIDER, ELIGIBILITY START DATE, REASSESS DATE, WAIT LIST

RESIDENTIAL CARE REFERRAL

Table with columns: FUNDING SOURCE, ACTION, REASON, 10-DAY, DISCHARGE DATE, DISCHARGE TO, and NOTICE DATES

SIGNATURE
Assessment Date Assessment Version Assessor Signature Signature Date

FOR OFFICE USE ONLY BEAS/BFI
APRC BEAS request date to
BFI approved begin date to